

New Hampshire Adult HIV/AIDS Case Report Form (Patients ≥ 13 years of age)

Mail completed form to: NH DHHS Communicable Disease Surveillance Section,
Attn: Heather Barto, 29 Hazen Drive, Concord, NH 03301-6504

I. HIV/AIDS SURVEILLANCE PROGRAM USE ONLY

State Number	Soundex Code	Report Status	Date Received	OOS State Number
		New Update	____/____/____	
Document Source	New Investigation	Report Medium	Surveillance Method	
A ____ - ____ - ____ - ____	Y N U		A F P R U	

II. PATIENT IDENTIFIER INFORMATION – data not transmitted to CDC

Patient Name: _____ Phone: () _____ - _____

Alt Phone: () _____ - _____ Current Address: _____

City: _____ County: _____ State: _____ Zip: _____

III. FORM INFORMATION

Date form completed: ____/____/____ Person completing form: _____ last first Phone: () _____ - _____

IV. CURRENT HEALTH CARE PROVIDER INFORMATION

Physician: _____ last first Facility: _____

City: _____ State: _____ Phone: () _____ - _____ Med Rec No: _____

V. DEMOGRAPHIC INFORMATION – complete ALL fields

Diagnostic Status: <input type="checkbox"/> Adult HIV <input type="checkbox"/> Adult AIDS	Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: ____/____/____	Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> US Depend/Posses <input type="checkbox"/> Unk <input type="checkbox"/> Other _____	Status: <input type="checkbox"/> Alive <input type="checkbox"/> Dead	Death Date: ____/____/____ State of Death: _____
Marital Status: S M W D Oth Unk	Ethnicity: Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (check all that apply): <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> Hawaiian/Pacific Islander			
Residence at Diagnosis: <input type="checkbox"/> Same as Current Street Address: _____ City: _____ County: _____ State: _____ Zip: _____					

VI. FACILITY OF DIAGNOSIS

Facility Name: _____

Physician: _____

Address: _____

City: _____

State: _____

Facility Type:

☐ Private Physician ☐ ER ☐ CTS
☐ Hospital Inpatient ☐ OB/GYN
☐ Hospital Outpatient ☐ Health Dept
☐ STD Clinic ☐ Corrections
 Other: _____

VII. PATIENT HISTORY – COMPLETE ALL FIELDS

Before the 1 st positive HIV test/AIDS diagnosis, patient had:	Y	N	U
➤ Sex with male			
➤ Sex with female			
➤ Injected drugs			
➤ Received clotting factor			
➤ HETEROSEXUAL contact with the following:			
• Injecting Drug User (IDU)			
• Bisexual male (applies to females only)			
• Person with hemophilia/ coagulation disorder			
• Transfusion recipient w/ documented HIV infection			
• Person with AIDS or documented HIV infection, risk unspecified			
➤ Received transfusion Date 1 st ____/____/____ Date last: ____/____/____			
➤ Received organ transplant, tissue or artificial insemination			
➤ Worked in healthcare/clinical lab OCCUPATION: _____			

VIII. LABORATORY DATA

HIV ANTIBODY TESTS AT DIAGNOSIS: (<u>FIRST</u> known pos. test)						
	RESULT			TEST DATE		
	Pos	Neg	Indet	Mo	Day	Yr
HIV-1 EIA						
HIV 1/2 EIA						
HIV 2 EIA						
HIV 1 Western Blot						
HIV 2 Western Blot						
Other: _____						

POSITIVE HIV DETECTION TEST: (<u>EARLIEST</u> known test)						
<input type="checkbox"/> NAT	<input type="checkbox"/> p24 Antigen					
<input type="checkbox"/> Qual PCR RNA	<input type="checkbox"/> Qual PCR DNA					

VIRAL LOAD TESTS: (record most recent and earliest)						
Type Name	Copies/ML	Mo	Day	Yr		
Select type:						
RNA RT-PCR						
RNA bDNA						
RNA NASBA						
Other						

IX. AIDS INDICATOR DISEASES

Clinical Record Reviewed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Initial Dx Date (mo/day/yr)	Presumptive	Definitive
Disease:			
Candidiasis, bronchi, trachea, or lungs	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Candidiasis, esophageal	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cervical cancer, invasive	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Coccidioidomycosis, disseminated or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cryptococcosis, extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cryptosporidiosis, chronic intestinal	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cytomegalovirus disease (other than liver, spleen, or nodes)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cytomegalovirus retinitis (with loss of vision)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
HIV encephalopathy	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Herpes simplex: chronic ulcers; or bronchitis, pneumonitis, or esophagitis	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Histoplasmosis, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Isosporiasis, chronic intestinal	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Kaposi's sarcoma	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma, Burkitt's (or equivalent)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma, immunoblastic (or equivalent)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma, primary in brain	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
M. tuberculosis, pulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
M. tuberculosis, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Mycobacterium of other or unidentified species, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Pneumocystis carinii pneumonia	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia, recurrent	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Progressive multifocal leukoencephalopathy	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Salmonella septicemia, recurrent	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Toxoplasmosis of brain	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Wasting syndrome due to HIV	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>

XII. COMMENTS (about partner(s), TB testing or history, STD testing or history, recently relocated, pregnancy, medical conditions, etc.):

IMMUNOLOGIC LAB TESTS:

At or closest to current diagnostic status	Mo	Day	Yr
CD4 Count: _____ cells/ul (_____%)			
CD4 Count: _____ cells/ul (_____%)			
First <200 or <14% of total lymphocytes			
CD4 Count: _____ cells/ul (_____%)			
CD4 Count: _____ cells/ul (_____%)			

PHYSICIAN DIAGNOSIS:			
If HIV lab tests were not documented, is HIV diagnosis documented by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			
If YES, provide date of physician documentation			

X. TREATMENT/SERVICES REFERRALS

Patient informed of his/her infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			
This patient's partners will be notified about their HIV exposure and counseled by:		This patient's medical treatment is primarily reimbursed by:	
<input type="checkbox"/> Health Department	<input type="checkbox"/> Medical	<input type="checkbox"/> Patient	<input type="checkbox"/> Unknown
<input type="checkbox"/> Medicaid/Medicare	<input type="checkbox"/> Private insurance	<input type="checkbox"/> No coverage	<input type="checkbox"/> Other public funding
<input type="checkbox"/> Clinic trial/program	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is patient enrolled in a clinic/clinical trial?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is patient receiving or been referred for:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• HIV related medical services?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Substance Abuse treatment services?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

XI. WOMEN ONLY

Is patient receiving or been referred for OB/GYN services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, physician _____
Is patient currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, what is expected due date? ____/____/____
Has patient delivered a live-born infant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, provide Grava ____ Para ____ & info below for most RECENT birth Date of Birth: ____/____/____ Hospital of Birth: _____ City: _____ State: _____ Zip: _____ Child's Name: _____ last _____ first _____ middle _____

For questions about HIV reporting call 603-271-3932